CLIENT REGISTRATION FORM

NAME (First/Last): _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: _____
(If Different) _____

EMERGENCY CONTACT INFORMATION *(Attach additional papers if more than one person):*

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

ETHNICITY

☐ HISPANIC OR LATINO
☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE, CAUCASIAN
☐ HISPANIC
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ ASIAN
☐ BLACK / AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER _____

If you do not speak English, what is your primary language?_____

☐ I was provided the *Notice of Privacy Practices*

YOUR INCOME IS:

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

☐ BELOW POVERTY **OR** ☐ ABOVE POVERTY

☐ BELOW 300% SSI **OR** ☐ ABOVE 300% SSI

DO YOU LIVE ALONE?	☐ Yes	☐ No
ARE YOU DISABLED?	☐ Yes	☐ No
ARE YOU FRAIL?	☐ Yes	☐ No
ARE YOU HOMEBOUND?	☐ Yes	☐ No
ARE YOU A CAREGIVER?	☐ Yes	☐ No

If you are a caregiver, who do you care for?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult Child
☐ Parent ☐ Family Member
☐ Other _____

Activities of Daily Living (ADLs)

Without assistance, I am unable to:

☐ Bathe ☐ Get Dressed
☐ Eat ☐ Use the Bathroom
☐ Walk ☐ Transfer In or Out of a Bed or Chair
☐ **None – I can perform these activities**

Instrumental Activities of Daily Living (IADLs)

Without assistance, I am unable to:

☐ Prepare Meals ☐ Do Light Housework
☐ Take Medication ☐ Do Heavy Housework
☐ Manage Money ☐ Use the Telephone
☐ Shop ☐ Use Transportation Services
☐ **None – I can perform these activities**

Client Signature _____ Date _____
(Initial or Revised Registration)

Client Signature – 2nd year _____ Date _____
(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For:
☐ _____
☐ _____

New to This Service?
☐ Y ☐ N
☐ Y ☐ N

Nutrition Risk Assessment Score: _____
Site: _____
Notes: _____

CLIENT REGISTRATION FORM

NAME (First/Last): _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ _____

MAILING ADDRESS: (If Different) _____ _____

EMERGENCY CONTACT INFORMATION:

NAME 1 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

NAME 2 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

ETHNICITY

☐ HISPANIC OR LATINO
☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE, CAUCASIAN
☐ HISPANIC
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☐ BELOW 300% SSI **OR** ☐ ABOVE 300% SSI

DO YOU LIVE ALONE?	☐ Yes	☐ No
ARE YOU DISABLED?	☐ Yes	☐ No
ARE YOU FRAIL?	☐ Yes	☐ No
ARE YOU HOMEBOUND?	☐ Yes	☐ No
ARE YOU A CAREGIVER?	☐ Yes	☐ No

If you are a caregiver, who do you care for?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult Child
☐ Parent ☐ Family Member
☐ Other _____

_____ _____ _____ _____

Client Signature *(Initial or Revised Registration)* | Date | Client Signature – 2nd year (I certify that my information has not changed.) | Date

FOR OFFICE USE ONLY

Services Registered For: ***New to This Service?*** ***Nutrition Risk Assessment Score:*** _____

☐ _____ ☐ Y ☐ N ***Client ID:*** _____

☐ _____ ☐ Y ☐ N **Notes:** _____